

**DEPARTMENT OF VETERANS AFFAIRS
ADVISORY COMMITTEE ON CHIROPRACTIC CARE IMPLEMENTATION
RECOMMENDATIONS TO THE SECRETARY OF VETERANS AFFAIRS**

May 10, 2005

INTRODUCTION

Public Law 107-135, Section 204 established the Department of Veterans Affairs (VA) Chiropractic Advisory Committee “to provide direct assistance and advice to the Secretary in the development and implementation of the chiropractic health program” within Veterans Health Administration (VHA). The Committee made numerous recommendations to the Secretary of Veterans Affairs regarding implementation of the chiropractic care program. In March 2004, VA concurred with a recommendation regarding program evaluation that stated:

“A formal evaluation of the challenges and benefits of providing chiropractic care within VHA should be completed by the conclusion of the third year of implementation. Formal progress reports should be completed at least annually and provided to the Secretary, the Under Secretary for Health, the Deputy Under Secretaries for Health, other members of the National Leadership Board, and made available to interested stakeholders.”

The VA Chiropractic Advisory Committee made additional recommendations regarding program evaluation in July 2004 and VA concurred with the intent of those recommendations.

Public Law 107-135 specified that the statutorily-mandated VA Chiropractic Advisory Committee would cease to exist on December 31, 2004. In January 2005, Secretary of Veterans Affairs Anthony J. Principi chartered a discretionary advisory committee, the VA Advisory Committee on Chiropractic Care Implementation, to advise the Secretary on implementation and evaluation.

RECOMMENDATIONS AND RATIONALE:

Recommendation 1: VA should arrange for all doctors of chiropractic practicing at VA facilities to attend the September 2005 meeting of the VA Advisory Committee on Chiropractic Care Implementation in order to provide input to the Committee and to share their experiences and lessons learned.

Rationale: The Committee believes that an opportunity to interact with the doctors of chiropractic working in VA facilities is essential for the Committee to understand how implementation is progressing and to fulfill its responsibilities to the Secretary as outlined in its charter: reviewing and evaluating policy and

program issues affecting implementation, recommending actions to improve the chiropractic care program, and assisting in long-range planning. Due to both the varied nature of the status of VA doctors of chiropractic (employed full-time and part-time, contracted part-time, fee basis and without compensation appointments) and the variations among the facilities selected for implementation (small/large, rural/urban, medical school affiliated/non-affiliated), the Committee would like to meet with all the doctors of chiropractic. In addition, the Committee believes, that as a new professional group within VA, it is essential that the doctors of chiropractic working in VA have an opportunity to meet and discuss areas of interest that will assist the chiropractic field advisory committee in its work.

Recommendation 2: VA should create and maintain up-to-date clinical guidelines on musculoskeletal conditions, specifically but not limited to low back pain, neck pain and headache. Doctors of chiropractic should be involved as appropriate in the development of such guidelines.

Rationale: Forty per cent of all VA rated service-connected disabilities are due to musculoskeletal conditions. However, VA currently has only one clinical practice guideline related to musculoskeletal conditions. The Clinical Practice Guideline entitled “Low Back Pain or Sciatica in the Primary Care Setting” was completed in 1998, released in November 1999, and approximately half of its references are 15 or more years old. Considering this prevalence of musculoskeletal conditions, it is essential that VA keep current the Guidelines it already has and explore the possibility of developing new ones.

Recommendation 3: VA should create a chiropractic field advisory committee composed of VA employees with the position of committee chair rotating among its members. The purpose of this committee will be to continue providing oversight of and advice on the chiropractic care program when the current VA Advisory Committee on Chiropractic Care Implementation expires December 31, 2005. As the program matures, VA should consider assignment of a Chiropractic Program Director.

Rationale: The VA Chiropractic Advisory Committee recommended in November 2003 that VHA should create a mechanism for providing oversight of and consultation on the implementation of chiropractic care. VA concurred, stating that “a mechanism to obtain input and advice from doctors of chiropractic practicing within the VA health care system is important in successfully implementing chiropractic care in VHA.” VHA has successfully used field advisory committees to ensure field input on programmatic issues.

The current VA Advisory Committee on Chiropractic Care Implementation will expire December 31, 2005. The Committee believes it would be useful to establish an internal VHA chiropractic field advisory committee in time to have

the Chair attend the last meeting of the VA Advisory Committee on Chiropractic Care Implementation in December 2005.

Recommendation 4: VA should consider the program evaluation questions identified by the Committee (Attachment A) and determine the feasibility of answering these questions, specifically if data collection could begin within one year. VA should also consider if data collection would be feasible in succeeding years, or if the questions cannot be answered due to unavailability of data or lack of resources to collect the data.

Rationale: The program evaluation elements identified by the Advisory Committee encompass the domains of quality used in VHA's quality and performance program, with the addition of additional elements pertinent to evaluation of a new program.

Recommendation 5: VA should encourage the development of additional academic affiliations to provide training opportunities and career path exposure for doctors of chiropractic within VA.

Rationale: In its November 2003 recommendations, the VA Chiropractic Advisory Committee stated that the goals of VHA's chiropractic care program should include full integration into all of VHA's missions, including education. At that time the Committee recommended that VA should provide opportunities for educational and training experiences for senior chiropractic students and recent graduates from chiropractic programs, consistent with graduate preceptor programs sponsored by chiropractic educational programs. VA currently has one academic affiliation with New York Chiropractic College that initially placed faculty and students at the Buffalo VA Medical Center and now has expanded to the Rochester VA Outpatient Clinic.

Attachment A: Recommended Program Evaluation Elements

In its November 2003 recommendations, the VA Chiropractic Advisory Committee stated that the goals for VHA's new chiropractic care program should include:

- Patients have access to chiropractic care.
- Doctors of chiropractic, physician providers and other clinicians develop collaborative relationships in order to provide the coordinated patient care necessary to meet the needs of veterans.
- Chiropractic care is fully integrated into all of VHA's missions – patient care, education, research and response to disasters and national emergencies.

The VA Advisory Committee on Chiropractic Care Implementation endorses those goals.

In this document, the Committee poses questions that it believes would be indicators of program success and that should be addressed by the program evaluation. The Committee requests that VA determine the feasibility of answering these questions, specifically if data collection to answer each question could begin within one year, if data collection is feasible in succeeding years, or if the questions cannot be answered due to unavailability of data or lack of resources to collect the data. The Committee would welcome VA suggestions for additional questions that should be evaluated.

1. Access:

Were veterans who are appropriate candidates for chiropractic care able to access such care?

While the ability to answer the above question may be lacking, answers to the following questions could provide information that would allow both the Committee and VA to reach conclusions regarding access:

- a. What is the waiting time for chiropractic clinic appointments? How does this compare with other specialty clinics? What percentage of clinics meets VHA's waiting time goal?
- b. What percentage of patients receiving on-station chiropractic care lives within the VHA travel time/distance standard of that VA facility?
- c. What percentage of patients receiving fee basis chiropractic care is within the VHA travel time/distance standard of a VA Medical Center not currently providing on-station chiropractic care?
- d. What percentage of referrals (for both on-station and fee basis chiropractic care) are patient-generated vs. provider recommended?
- e. What percentage of referrals (on-station or fee basis) is generated from CBOCs, for inpatients?

- f. Are patients required to see another provider before being referred for on-station or fee basis chiropractic care?
- g. How long does it take for patients to receive fee basis authorization for chiropractic care, from the time the provider makes the referral to the time the authorization is received?
- h. How many complaints have facility patient advocates received and how many clinical appeals have been filed regarding denial of referral to 1) on-station chiropractic care or 2) fee basis chiropractic care?
- i. Question #3 on the annual Survey of Healthcare Experience of Patients (SHEP) (Were you able to get an appointment as soon as you wanted?) may also provide some data.
- j. Add the following question to the national survey of patients: Have you ever wanted chiropractic care and not been able to get it?

2. **Quality of care:**

What is the quality of the chiropractic care that VA provides?

The Committee strongly believes that VA should develop measures of the quality of care provided for musculoskeletal conditions to be incorporated into VHA's performance measurement system. In the absence of clearly defined quality of care measures for musculoskeletal care or chiropractic care, this domain of care will likely be the most difficult to evaluate. Surrogate questions regarding both process and identifiable problems may provide the only information obtainable at this point in time.

- a. What problems, if any, have been identified by patients or VA providers with the quality of chiropractic care that VA provides on-station or through fee basis?
- b. Does each VISN have a documented and functioning peer review process in place for chiropractic care?
- c. In addition to other elements generally examined during the peer review process, are the following elements documented in the patients' records?
 - absence of major contraindications,
 - review of appropriate diagnostic studies,
 - treatment plan including duration of treatment and methods of evaluating progress,
 - if adjustments are rendered, the segments adjusted,
 - evaluation of progress/outcome – documentation of endpoints such as relief of pain, restoration of motion, return to prior activity level, reduction of medication utilization, and patient's perception of improvement in quality of life.
- d. Questions #32 on the annual SHEP (Was the main reason you came for this visit addressed to your satisfaction?) and # 34 (Overall, how would you rate the quality of this visit?) may also provide some data. However, it may be necessary to over-sample patients with chiropractic visits in order to obtain sufficient data to draw conclusions.

3. Patient outcomes – functional status:

Does chiropractic care improve patient's function and/or relieve their pain?

VA's Office of Research and Development (ORD) has issued a Request for Applications on Chiropractic Research. One of the "sample research issues" in this solicitation concerns the efficacy, effectiveness and cost of spinal manipulative therapy. In addition, the Committee encourages VA to utilize its integrated healthcare system to build an evidence base for valid outcome measures. VA should begin by implementing a standardized package of measurements, such as the Oswestry scale for low back pain and the Neck Disability Scale in addition to VA's standard pain scale, to provide pre-and post-treatment measurements for those conditions, regardless of the provider's profession, and including care provided through off-station fee basis providers. The Committee understands that retrieval of data from patient records is time-consuming and therefore expensive unless the data can be gathered electronically. The Committee encourages VA to consider ways in which this type of outcome data can be economically gathered.

In the meantime, for the purpose of evaluating the chiropractic care program, data from Questions #32 on the annual SHEP (Was the main reason you came for this visit addressed to your satisfaction?) and # 34 (Overall, how would you rate the quality of this visit?) may provide some insight.

4. Patient satisfaction:

Are patients seen by doctors of chiropractic satisfied with their care?

The questions on the annual SHEP will provide data, although it most likely will be necessary to over-sample patients with chiropractic visits in order to obtain sufficient data to draw conclusions.

5. Cost/revenue:

What is the cost/benefit of chiropractic care?

As noted above, VA ORD has included cost as a potential research issue in its solicitation for chiropractic care research. In the meantime, the following questions will provide both the Committee and VA with information regarding the cost of establishing the chiropractic care program, maintaining it, and whether any costs can be recovered by billing third party payers:

- a. What costs were associated with implementation of the chiropractic care program, including space renovation and equipment?
- b. What does it cost to maintain a chiropractic clinic?
- c. What are the VA-calculated costs of providing on-station chiropractic care - costs per patient visit, per patient course of therapy including diagnostic studies?

d. What are the costs of providing fee basis chiropractic care – costs per patient visit, per patient course of therapy including diagnostic studies whether provided at VA or by a community doctor of chiropractic?

e. What percentage of visits could be billed to third party payers? What was the recovery rate and amount?

6. Patient safety:

While reports of serious adverse effects from spinal manipulative therapy are rare, systematic data is lacking. The VA ORD solicitation also includes patient safety as a research subject. In light of the research opportunities provided within a large integrated healthcare system, the Committee encourages VA to consider the long-term goal of establishing a database similar to that used by the National Surgical Quality Improvement Program. In the meantime, the chiropractic care program evaluation should include the following questions:

a. Were any adverse events related to chiropractic care reported? Were any adverse effects resulting from spinal manipulation by any provider (doctors of osteopathic medicine or physical therapists, as well as doctors of chiropractic) reported?

b. Did peer review reveal any safety issues?

c. Did monitoring of service referral agreements, as done in VISN 23, result in evidence of inadequate screening and/or inappropriate referrals (patients with major detectable contraindications)?

7. Collaborative relationships:

The Committee views the development of collaborative relationships among doctors of chiropractic, physicians and other clinicians in providing coordinated patient care as necessary to the success of the chiropractic care program, and suggests that evaluation of this may require a survey of providers.

a. Do non-chiropractic provider perceptions of doctors of chiropractic/chiropractic care change over time? How do they perceive the degree of collegiality that has been achieved? How do they perceive the coordination of care across providers and sites of care? Do these perceptions vary with the characteristics of the non-chiropractic provider (age, years of experience, primary practice specialty, and percentage of patients with musculoskeletal conditions, prior experience with doctors of chiropractic, having referred to or received referrals from a doctor of chiropractic)?

b. Do VA doctors of chiropractic perceive that they have been able to develop collaborative relationships with the other clinicians with whom they work most closely? How do they perceive the degree of collegiality that has been achieved? How do they perceive the coordination of care across providers and sites of care?

c. Do the doctors of chiropractic work within multidisciplinary teams where they are included in patient evaluation/treatment planning meetings?

- d. Have referrals for chiropractic care increased over time? Have additional practitioners made referrals over time?
- e. Have the doctors of chiropractic made referrals to other clinicians?
- f. Have the service referral agreements been revised since initial implementation? If so, who or what prompted that?
- g. Can best practices for service referral agreement be identified?

8. Full Integration:

The Committee understands the difficulty of evaluating this success factor, and notes that the VA ORD solicitation includes health systems research as a topic of interest. In the absence of a research project, the following questions may provide information that can be used to assess the integration of chiropractic into VHA. The Committee does not expect that all of these items will be attainable immediately, but it does believe all should be present or have been initiated within 3 years of implementation.

- a. Have clinical practice guidelines for musculoskeletal conditions been developed/updated? Has chiropractic care been incorporated into clinical practice guidelines as appropriate? Have doctors of chiropractic been included in the development of such guidelines?
- b. Has a VHA chiropractic field advisory group been established? Does it meet regularly and provide input to VHA?
- c. Does the planned evaluation of the program continue after the charter of the Advisory Committee on Chiropractic Care Implementation expires? Are reports issued at annual intervals during the three year course of the evaluation as recommended by the Chiropractic Advisory Committee?
- d. Is there at least one funded ORD research project with a doctor of chiropractic as a co-investigator?
- e. Do the expectations of VA clinical education requirements apply to doctors of chiropractic, e.g., completion of the Veterans Health Initiative modules, etc.
- f. Are doctors of chiropractic incorporated into in-service presentations, grand rounds, and other clinical education presentations?
- g. Are doctors of chiropractic considered members of the medical staff? How does their status compare to that of other independently licensed non-physician providers such as podiatrists and optometrists, other contract or fee-basis appointed providers?
- h. How many academic affiliations have been initiated with chiropractic programs? What types of educational activities/programs have been initiated? How many chiropractic students have had clinical rotations in VA facilities? Have any of those students been hired by VA?
- i. Are doctors of chiropractic involved on facility/VISN/national committees?
- j. Can best practices for integration be identified?

9. Other data needs:

a. Information on the doctors of chiropractic practicing within VHA:
(1) Demographics –age, amount of experience when hired, school attended, post-graduate training.

(2) Prior experience in a multi-disciplinary setting.

(3) Privileges granted. Did privileges change over time?

(4) What is the retention/turnover rate for doctors of chiropractic?

What were the reasons for leaving?

(4) How many candidates declined positions when offered?

Reasons?

b. Organizational administrative/information:

(1) Organizational placement within facility. Did this change over time?

(2) Space allocation and location within facility. Are chiropractic examination/treatment rooms incorporated into the clinic area of the doctor of chiropractic's "home" service or are they separated? How many examination/treatment rooms are there per doctor of chiropractic in the clinic?

(3) Does the doctor of chiropractic have dedicated support staff for clerical duties? For clinical support duties such as providing hot packs, etc.?

(4) What equipment was purchased for the chiropractic clinic? Who selected the type of table(s) purchased?

(5) Did any facilities choose to use the doctor of chiropractic within their occupational health program? How used?

(6) Were any doctors of chiropractic requested to participate in the compensation and pension process?

c. Patient data:

(1) Diagnoses treated and major co-morbidities (ICD-9 codes).

(2) Age.

(3) Prior chiropractic care; including from DoD while on active duty.

(4) Other prior modalities (physical therapy, medications, etc.).

d. Workload data:

(1) On-station – number of patients, number of visits (clinic stops).

(2) Fee basis- number of patients, number of visits, costs including those in addition to manipulative therapy.

e. Evaluation of orientation process; specific educational needs of doctors of chiropractic.

f. Evaluation of distribution and use of patient information/education brochure.